IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

November 9, 2006

FILE COPY

Rhonda Repp, Administrator
Virginia Rose Resident Inn
2525 N Maple Grove Rd
Boise, ID 83704

Dear Ms. Repp:

On November 2, 2006, a complaint investigation survey was conducted at Virginia Rose Resident Inn. The survey was conducted by Patrick Hendrickson, R.N. and Jamie Simpson, MBA, QMRP. This report outlines the findings of our investigation.

**Complaint # ID00002139**

Allegation #1: An Identified resident was transported to the hospital due to "Refusal to get out of wheelchair" and after being seen by the emergency room the facility refused to admit the resident back to the facility.

Findings: Based on interview and record review it was determined the identified resident was transported to the hospital due to "refusal to get out of her wheelchair" and after being seen by the emergency room the facility did refuse to re-admit the resident back to the facility.

Review of the residents record on November 2, 2006 revealed the resident was admitted to the facility on October 9, 2006 and required one person assist to transfer.

The resident record contained caregiver progress notes that documented on October 28, 2006 at 9:00 a.m. the resident could stand with no problems and ambulated in and out of the tub with minimal assistance.

Review of the facility's "Incident/Accident Report" log on November 2, 2006 revealed on October 28, 2006 the identified resident "would not stand and get out of chair from 11:00 a.m. to 8:00 p.m." It further documented the resident was

transported to the local hospital via "ambulance" for a "medical and phycological evaluation."

On November 2, 2006 the identified resident's emergency department records dated October 28, 2006 were reviewed. The records revealed the resident was evaluated for complaints of "inability to get out of her wheelchair." Further, the records documented the residential care facility to which the resident was transferred from "refused to take the resident back" due to the residents increased level of care. The records documented the identified resident was then transferred via ambulance to a second residential care facility.

Review of the identified residents records from the second residential care facility on November 2, 2006 documented the resident was admitted on October 29, 2006 at 1:00 a.m.

Further review of the records revealed a "Patient Discharge Instructions" form dated October 29, 2006 that documented the resident was transported back to the local hospital "via ambulance."

The record also contained a "Interdisciplinary Progress Note" that documented the identified resident was transferred back to the hospital due to the "physical condition" of the resident and the need for a medical hospitalization.

On November 2, 2006 the identified residents hospital records dated October 29, 2006 were reviewed. The records revealed the resident was admitted to the hospital on October 29, 2006 at 9:00 a.m. with a diagnosis of lithium toxicity.

On 11/1/06 at 1:50 p.m. a caregiver at the second facility stated the resident was admitted on October 29, 2006 at 1:00 a.m. However, in the morning around 7:30 a.m. the resident was on the toilet and was unable to get up from the seated position. The care giver stated the facility called 911 and it took "many" firefighters to assist the resident off the toilet, out of the bathroom and into the ambulance that took her back to the local hospital.

On November 2, 2006 at 7:10 a.m. a caregiver at the first facility stated on October 28, 2006 at 9:00 a.m. she had assisted the resident with no problems that morning and the resident was able to ambulated in and out of the tub with minimal assistance. She further stated the identified resident later would not stand and get out of the wheelchair and "many firefighters" were needed to transport the resident into the ambulance.

On November 2, 2006 at 8:30 a.m. the owner stated a staff member notified her about the residents inability to ambulate and knew the resident was transported to the hospital. She further stated the resident by report was above the facility's level of care and did tell the hospital that they were unable to provide services to the

resident.

Review of the facility's "Admit Agreement" on November 2, 2006 revealed under the "Conditions of Termination of the Admission Agreement" in an emergency situation a resident may be transferred out of the facility without thirty days notice to protect the resident from harm.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by following the facility's "Conditions of Termination of the Admission Agreement" as the resident did have an acute medical problem and became above the level of care for the facility.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

PATRICK HENDRICKSON, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program